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Letters to the Editor – MJA

COVID-19 precautions – easier said than done when patients are homeless

Implementation of advice to the public and General Practitioners on minimising risk of COVID exposure and transmission is immensely difficult for people experiencing homelessness and the health services working with them. Yet this is a population group more vulnerable to infection than most.[1] The elevated risk factors for COVID are substantial, as people experiencing homelessness have a much higher prevalence of co-morbidity and chronic disease compared to people of the same age who are housed.[2] To illustrate further, among the 4000 active patients seen by Homeless Healthcare (Australia's largest specialist Homelessness GP practice based in Perth), nearly all patients have co-morbidities, 13% have chronic respiratory conditions, 79% smoke (associated with poorer lung health and risk) and 8% have diabetes (associated with supressed immunity). Attending an international Homelessness and Health conference this week in London,[3] we are seeing parallel calls in Australia and the UK for clearer government guidance as to how the precautionary measures can be applied in homeless populations. There are a myriad of challenges to this both for people who are homeless themselves, and for those providing healthcare to this vulnerable population group. These challenges include:

1. Regular hand washing and hygiene (and accessing soap or sanitiser and bathrooms in order to do this) is extremely problematic if living on the street.
2. Self-isolation by staying at home if you feel unwell and suspect having symptoms is impossible if you don't have a home to live in.
3. Reducing face-to-face health service contact is being advocated to GPs and health services in Australia and the UK. . The Australian government has just announced Medicare rebates for bulk billed telephone consults[4] but this is problematic for people who are homeless without a phone. Similarly, technological 'solutions' such as video/virtual consultations are digitally prohibitive for people without a home let alone a computer.
4. Outreach health services are among the most effective ways of enabling people who are rough sleeping to access healthcare[5] – Homeless Healthcare for example runs clinics at drop-in centres and crisis accommodation settings, and has nurses out on the streets each day and doing home visits to those recently housed. Implementing Personal Protective Equipment is however difficult in these settings, and in the absence of primary care outreach, ED presentations are likely to escalate.
5. Cancelling outreach GP clinics and other outreach services for this population to reduce exposure risks would have severe unintended consequence. If risk factors for COVID or COVID infections are untreated in this highly susceptible population, the mortality risk is high[1]. Moreover, many people will not receive critical treatment for other medical conditions such as depot medications for psychotic illness, and as articulated in a paper published in The Lancet (Public Health) this week, "lockdowns and disease containment procedures might also be deleterious to the mental health of people experiencing homelessness, many of whom have fears around involuntary hospitalisation and incarceration."[1]

The higher risks of COVID for people experiencing homelessness, and consequently, those working closely with them present an enormous challenge that has no easy answers – but as new precautionary measures are being announced daily, it is critical that further marginalisation for this group is not an unintended consequence.

References:

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